Coverage and Financial Impacts of Insurance Market Reforms in Minnesota

Jonathan Gruber, MIT
Bela Gorman, Gorman Actuarial
November 17th

Introduction
Who are we?

- Dr. Jonathan Gruber
  - Professor of economics at MIT since 1992
  - Member of the MA Connector Board
  - Technical support for states (notably MA) and federal government (developing ACA)
- Bela Gorman
  - Consulting health care actuary with 20 years of health care experience
  - Provides actuarial consulting analyses and expertise to various state governments on the impacts of health reform and various policy initiatives on the insured markets
  - Provides actuarial assistance to various insurers in preparation for the ACA

Introduction

Why are we here?

- Affordable Care Act (ACA) has transformative impacts on insurance markets in MN
- We jointly model impact of the ACA
- Economic modeling: population flows
- Actuarial modeling: insurance pricing
- Integrate the two to provide comprehensive analysis of population movements & costs

Key Findings

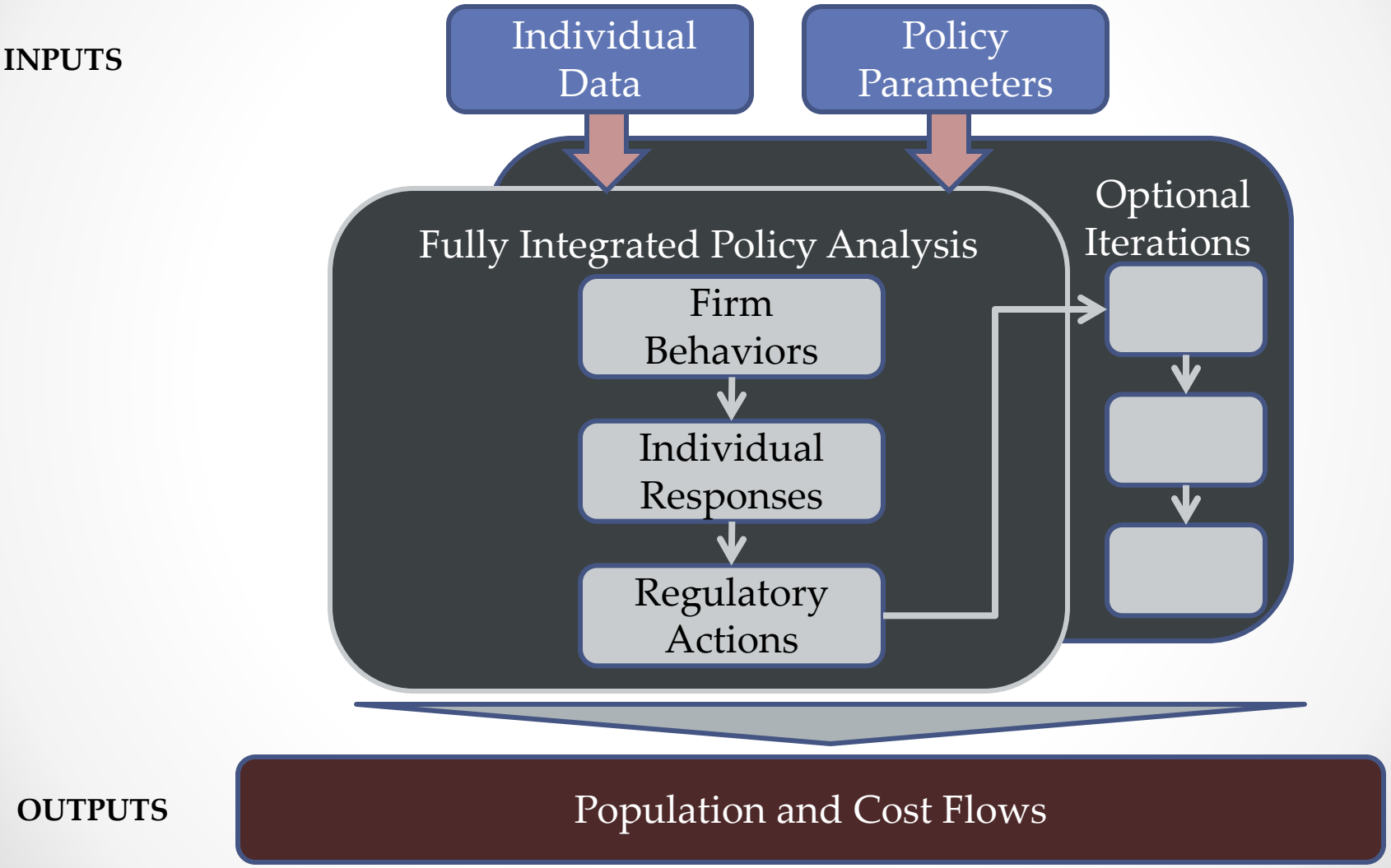
- Almost 300,000 Minnesotans gain insurance coverage
  - Small erosion in employer sponsored insurance
  - More than one million individuals obtain coverage in new exchange including individual, small group, 51-100 market, Medicaid, and potentially Basic Health Populations
- State spending impacts vary from state net costs of $150 million to state net gain of $275 million
  - Key determinants are Maintenance of Effort on MNCare and decisions regarding Basic Health Plan
- Household budgets improve by $500 to $700 per household
- Individual market enrollees see decline in premiums (after tax credits) of 20-25% on average

Part I:Background on Modeling

Microsimulation Modeling

- This is a fancy name for modeling how policies impact the economy
- Key aspect is accounting for how individuals and firms react to policy interventions
- Translating the results of basic health economics research into policy outcomes

Schematic of the Model



Data

- Base data is Minnesota Household Survey
  - Representative sample of 12,000 households, with information on insurance, income, etc.
- Augmented with survey data from individual, small group, 51 to 100 insurers
  - Insurers representing 94% of the Individual Market and 90% of the Small Group Market
  - Data on enrollment, premiums, risk mix, and benefits
- Public insurance eligibility, enrollment, benefits, risk mix & costs from state
- Data on large group premiums from MEPS-IC and 51 to 100 MN Insurer Data

Actuarial Analysis & Modeling

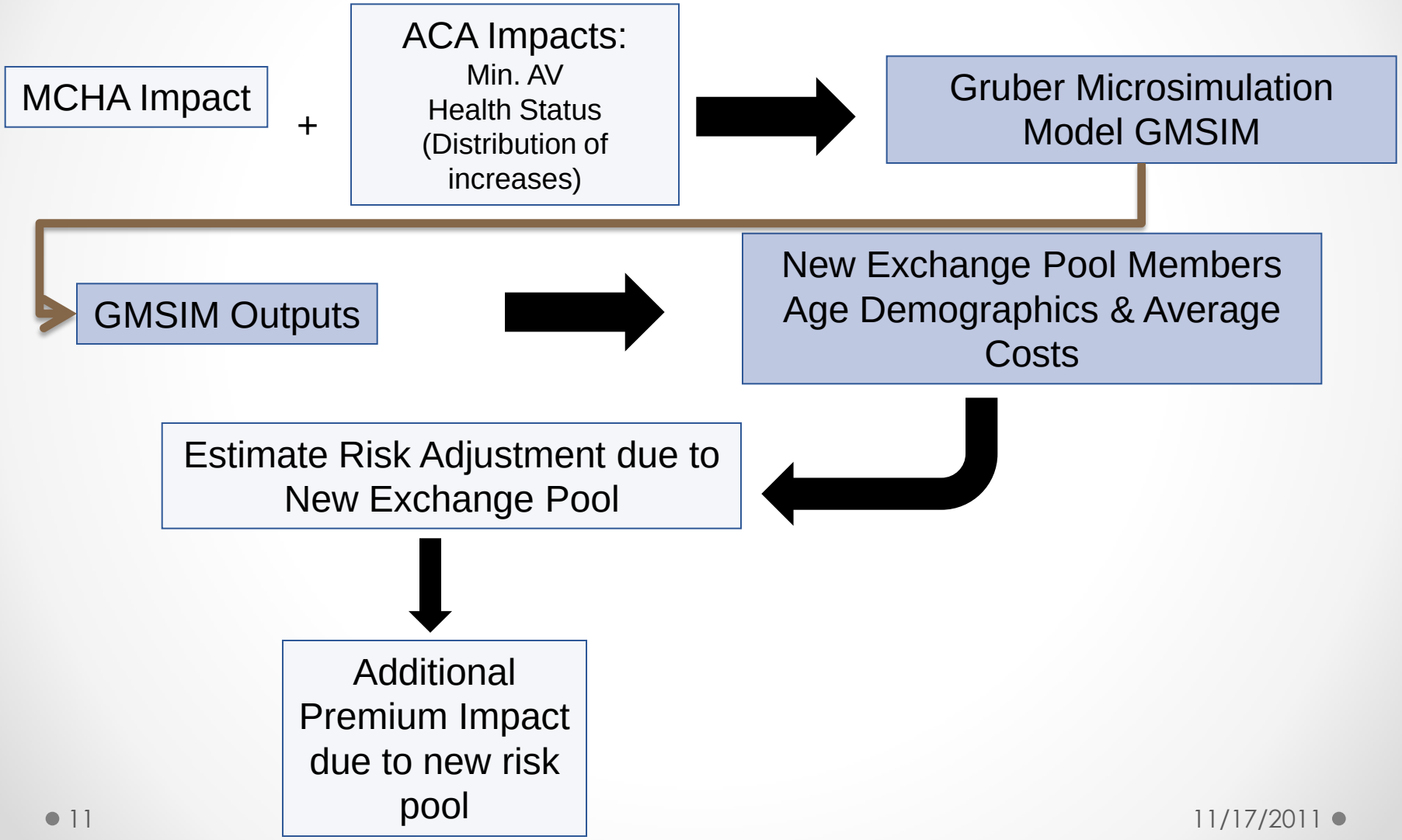
- Utilized MN Carrier Specific data
  - Detailed Plan Design Information for the Individual, Small Group Markets and 51-100 Market
  - Claims distributions for each market
  - Distribution of health status surcharges and discounts for each market
  - Premium, Claims, Member Month Exposure, and demographic distributions for each market
  - Aggregated data across carriers when possible
- Estimated Actuarial Value for each plan design offering
  - Actuarial Value is defined as percent of medical services paid for by the insurer
  - Actuarial Value was calculated by reviewing key cost sharing elements for each product offering
    - Deductible/Coinsurance/Out of pocket Maximum
    - Copays (office visit, inpatient, outpatient surgery)
    - Pharmacy benefit
  - Estimated premium impact due to the essential benefit requirement (bringing everyone up to 0.60 AV)

Actuarial Analysis & Modeling

- Health Status Rating Variable Analysis
  - Carriers will no longer be allowed to use health status as a rating variable
  - We assume there will be “winners & losers” but no change to the overall premium
- Modeled the premium impact of the high risk pool entering the Individual Market
- Results of actuarial modeling provided to Dr. Gruber for economic modeling
- Merged Market Analyses

Minnesota

Actuarial/Economic Interface



Model Key elements of ACA

- Medicaid expansion to 133% FPL
  - Adults in MNCare above 133% FPL to exchange
  - Maintenance of Effort considerations
    - Case 1: kids > 150% FPL to exchange
    - Case 2: kids > 275% FPL to exchange
- Tax credits for 133% FPL to 400% FPL
- Individual mandate
- Insurance market reforms
  - Community rating, guaranteed issue, no pre-ex
  - Minimum actuarial value
  - High Risk Pool Impact
- Employer responsibility payments
- Small firm tax credits
- Payroll tax financing from highest incomes
- State insurance exchange

Part II: Impacts On Coverage

Case I: Public Coverage for Children to 150% FPL

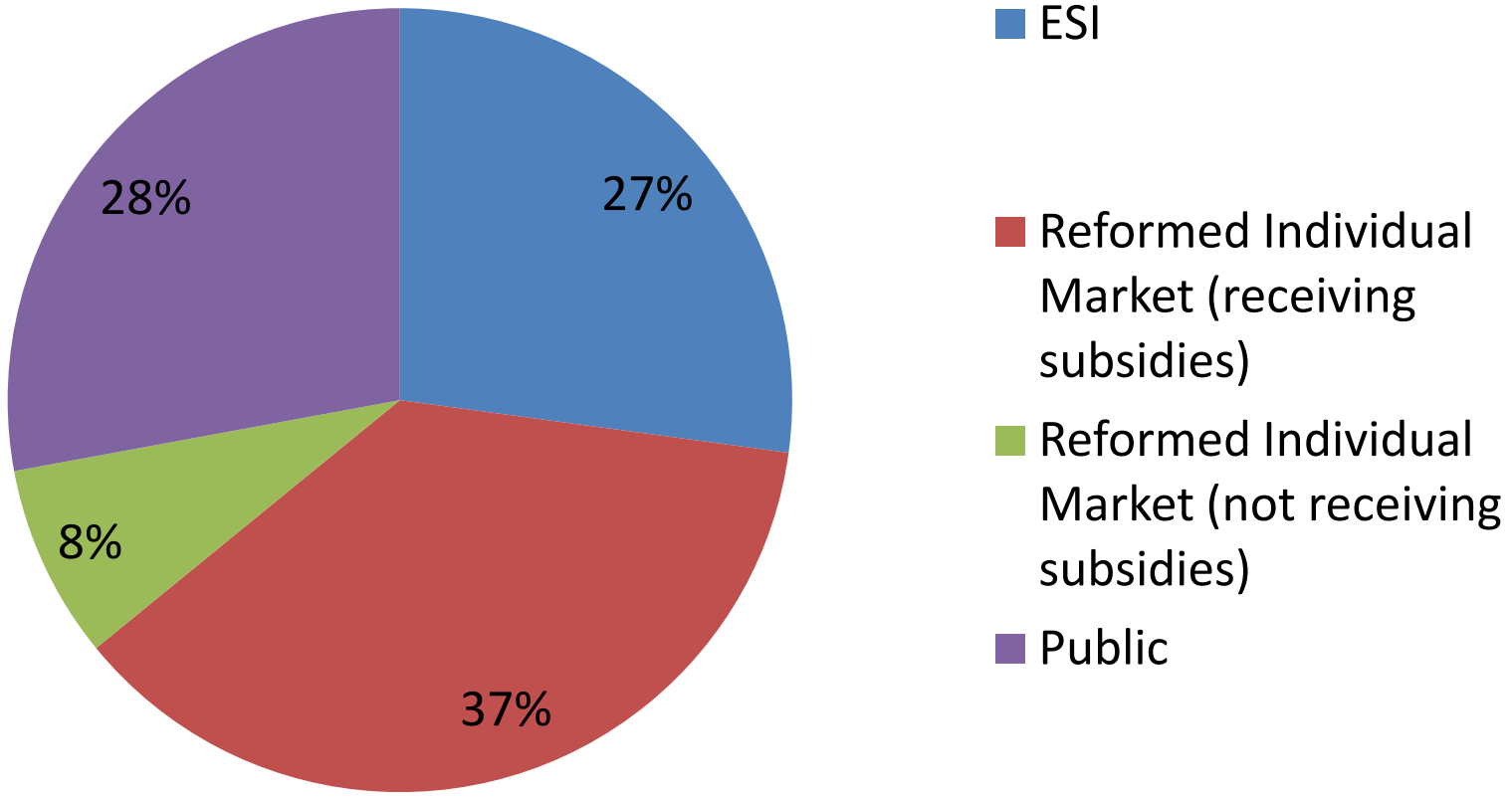
Estimate of ACA Effect: 2016

	No Reform	With ACA	ACA Impact
ESI	3,120,000	3,110,000	-10,000
>Small Firm ESI (1-50 employees)	450,000	440,000	-10,000
51 – 100 employees	120,000	120,000	0
Unreformed Individual Market	260,000	40,000	-220,000
Reformed Individual Market	0	520,000	520,000
Public Insurance	510,000	500,000	-10,000
Uninsured	500,000	220,000	-280,000
Total	4,390,000	4,390,000	

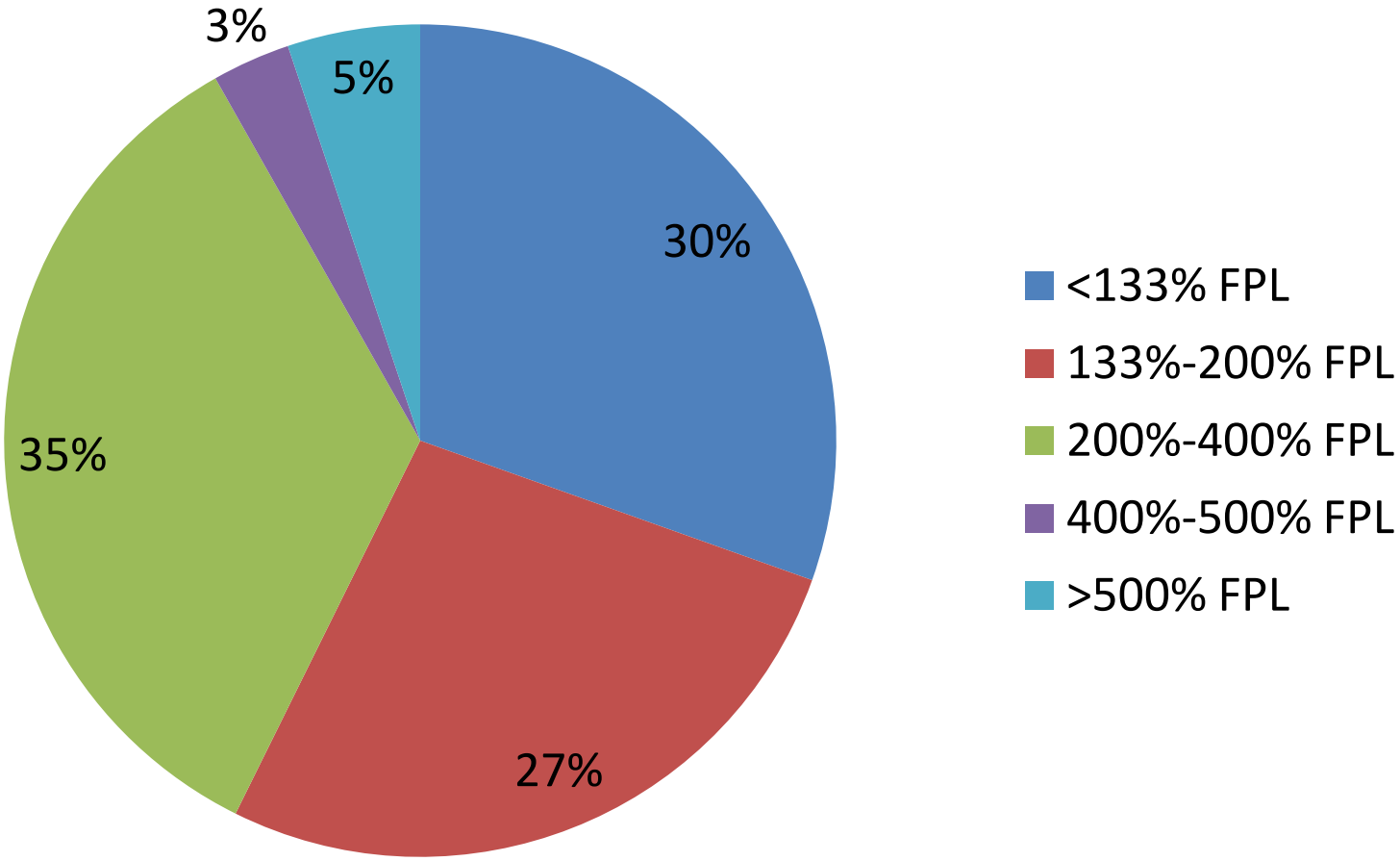
Changes in Public Enrollment Due to ACA: 2016

Leaving Public due to MN Care Ending	120,000
Leaving Public Voluntarily	0
Joining Public, Newly Eligible due to Expansion up to 133% FPL	50,000
Joining Public, Previously Eligible	60,000
Net Change	**-10,000**

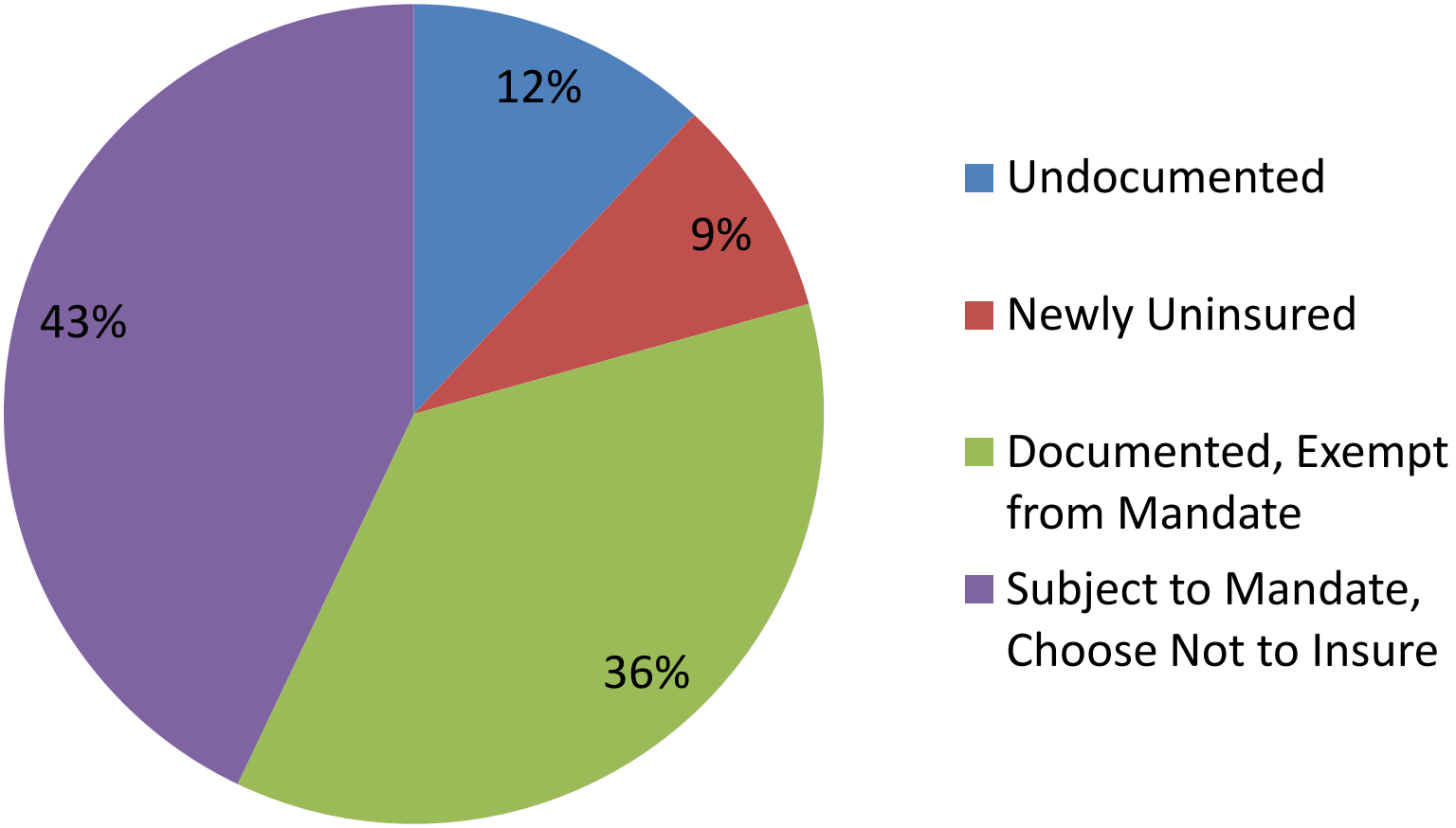
Coverage Sources of the Newly Insured: 2016

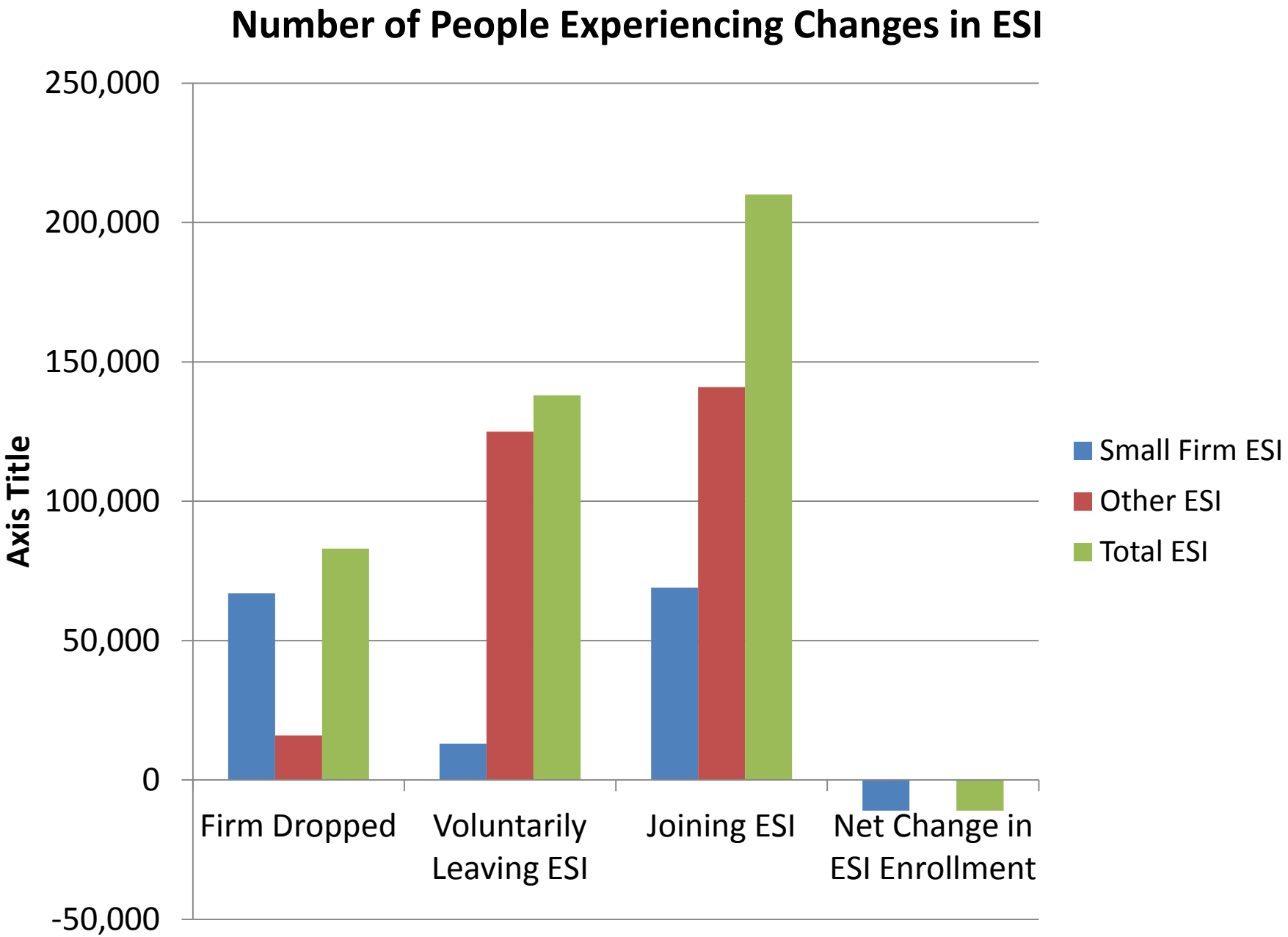


Newly Insured by Income: 2016



Remaining Uninsured: 2016




Number of People Experiencing Changes in ESI
250,000
200,000
150,000
100,000
50,000
0
-50,000
Axis Title
Firm Dropped
Voluntarily Leaving ESI
Joining ESI
Net Change in ESI Enrollment
Small Firm ESI
Other ESI
Total ESI

Predicting the Size of the Exchange, 2016

	No BHP		With BHP	
	# of individuals	Enrollment in the Exchange	# of individuals	Enrollment in the Exchange
Tax credit Recipients	390,000	390,000	240,000	240,000
Enrollees in Firms <50 Receiving Tax Credit	70,000	70,000	70,000	70,000
Non-tax Credit Recipients in Reformed Market	Up to 130,000	70,000	Up to 130,000	70,000
Enrollees in Firms <50 Not Receiving Tax Credit	Up to 380,000	95,000	Up to 380,000	95,000
Enrollees in firms 50-99	Up to 100,000	25,000	Up to 100,000	25,000
Public Insurance Enrollees	500,000	500,000	660,000	660,000
Total Exchange Enrollment		1,150,000		1,160,000

Part II: Impacts On Coverage

Case II: Public Coverage For Children to 275% FPL

Estimate of ACA Effect: 2016

	No Reform	With ACA	ACA Impact
ESI	3,120,000	3,110,000	-10,000
>Small Firm ESI (1-50 employees)	450,000	440,000	-10,000
>51 – 100 employees	120,000	120,000	0
Unreformed Individual Market	260,000	40,000	-220,000
Reformed Individual Market	0	400,000	400,000
Public Insurance	510,000	630,000	120,000
Uninsured	500,000	210,000	-290,000
Total	4,390,000	4,390,000	

Changes in Public Enrollment Due to ACA: 2016

Leaving Public due to MN Care Ending	50,000
Leaving Public Voluntarily	0
Joining Public, Newly Eligible due to Expansion up to 133% FPL	50,000
Joining Public, Previously Eligible	120,000
Net Change	**120,000**

Predicting the Size of the Exchange, 2016

	No BHP		With BHP	
	# of individuals	Enrollment in the Exchange	# of individuals	Enrollment in the Exchange
Tax credit Recipients	270,000	270,000	170,000	170,000
Enrollees in Firms <50 Receiving Tax Credit	70,000	70,000	70,000	70,000
Non-tax Credit Recipients in Reformed Market	Up to 130,000	70,000	Up to 130,000	70,000
Enrollees in Firms <50 Not Receiving Tax Credit	Up to 380,000	95,000	Up to 380,000	95,000
Enrollees in firms 50-99	Up to 100,000	25,000	Up to 100,000	25,000
Public Insurance Enrollees	630,000	630,000	730,000	730,000
Total Exchange Enrollment		1,160,000		1,160,000

Part III: Impacts to Premiums Individual and Small Group Market

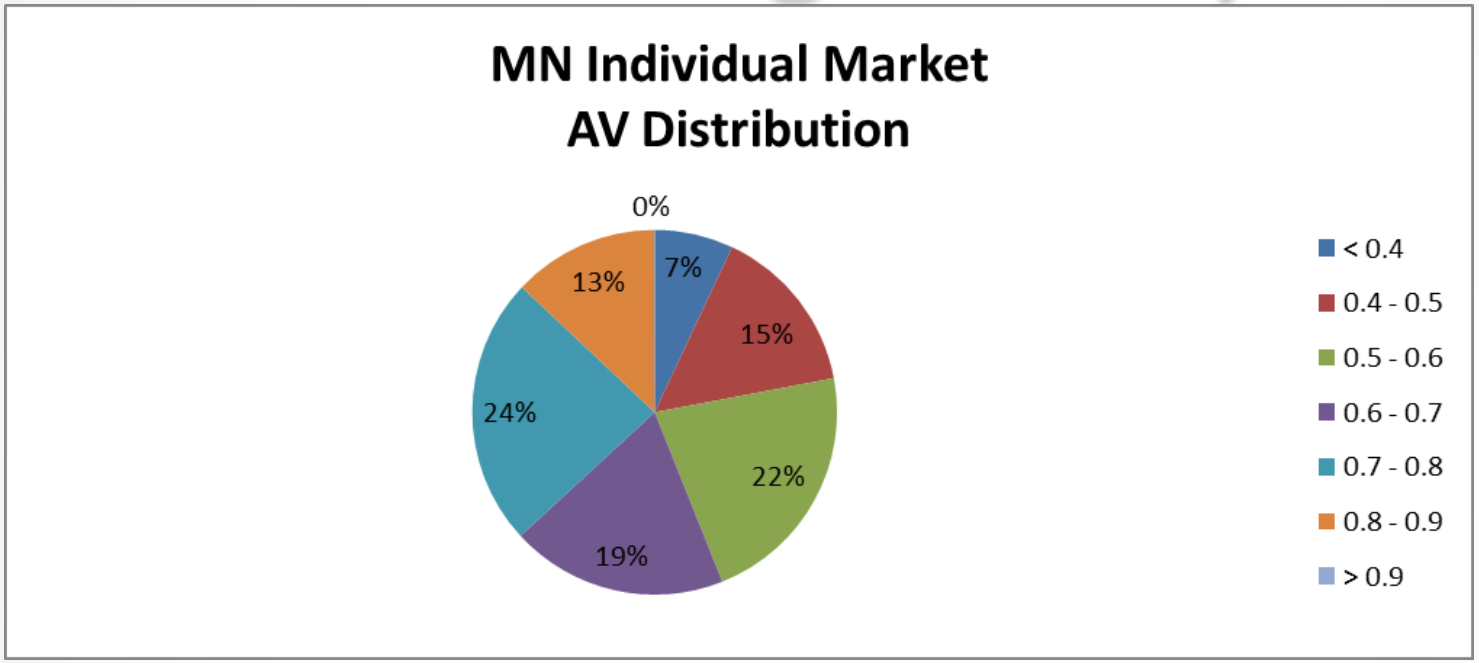
Plan Design Analysis

Single Policy In Network Deductible	% Individual Market	% Small Group Market
$0	0.1%	21.7%
<= $1,000	13.1%	34.1%
$1,150 - $2000	33.9%	17.9%
$2,100 - $3,000	18.2%	26.2%
$3,100 - $5,000	25.5%	0.1%
$5,100 - $9,300	3.6%	0.1%
$10,000	4.6%	0.0%
$15,000	0.9%	0.0%

Based on 2009 data

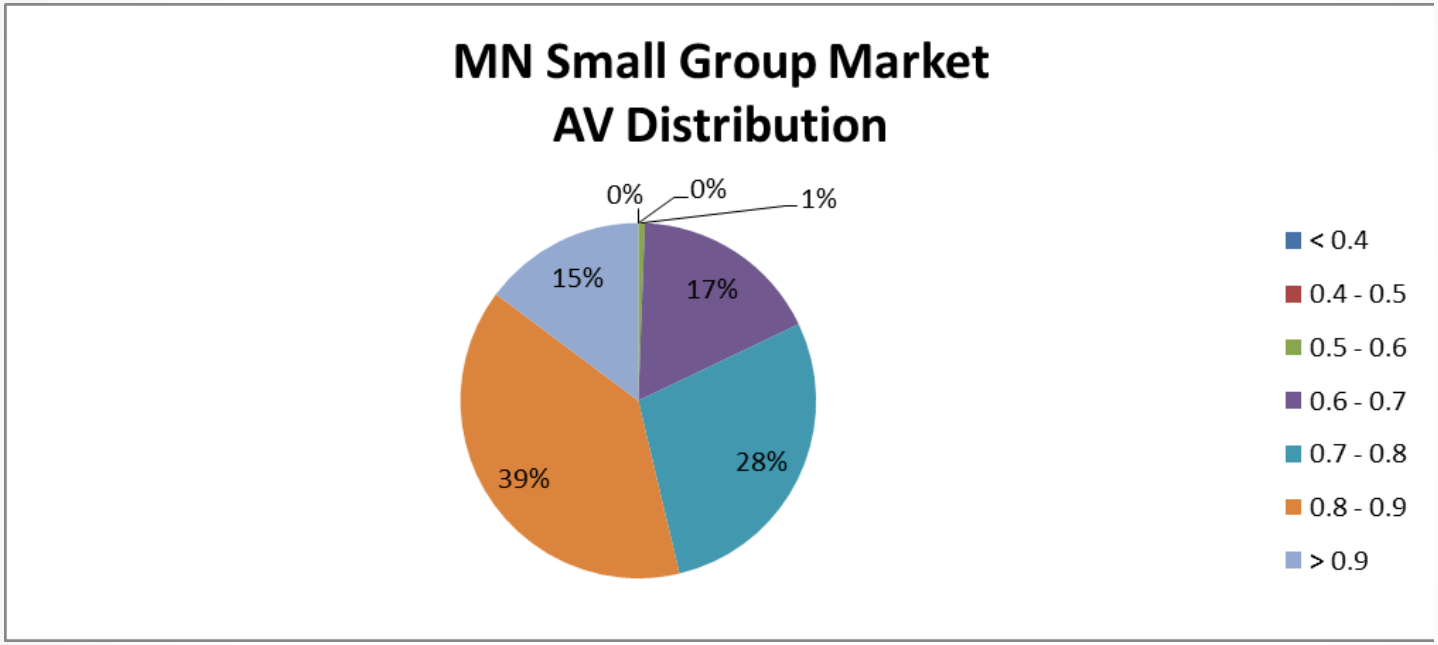
- Analyzed plan designs for the Small Group and Individual Market
- Approximately 22% of the Small Group Market has $0 deductible (mostly copay plans) this contrasts with the Individual Market where virtually no one is enrolled in a $0 deductible plan
- Approximately 35% of the Individual Market has greater than a $3,000 deductible as compared to 0.2% of the Small Group Market

Plan Design Analysis



- Overall Individual Market AV estimated at 0.63
- 22% of the market below a 0.5 AV and another 22% between 0.5 and 0.6
- Premium Impact due to Minimum Essential Benefit Requirement estimated at 8% to 11%

Plan Design Analysis



- Overall Small Group Market AV estimated at 0.79
- Less than 1% of the market has less than 0.5 AV
- Minimal premium impact due to Minimum Essential Benefit Requirement

Elimination of Health Status Adjustment: Individual Market

- Health underwriting is variable across the carriers
- Carriers who “aggressively underwrite” today will experience greater premium disruption
- Those carriers that moderately underwrite will experience lesser premium shocks
- Premium changes range from -7% to +18%

Elimination of Health Status Adjustment: Small Group Market

MN Small Group Market

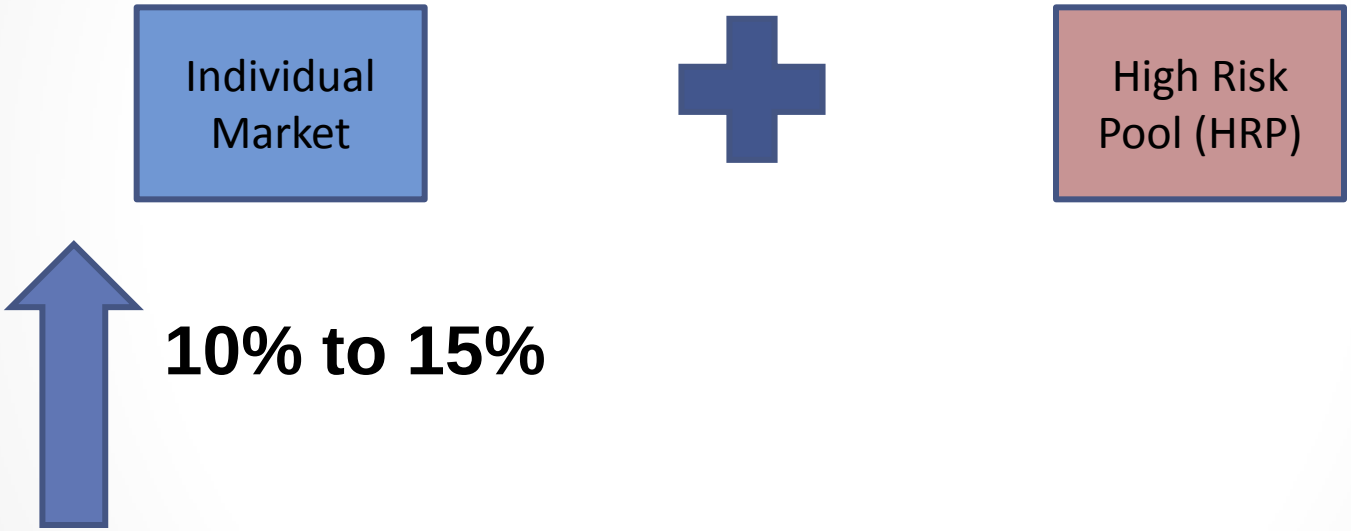
Premium Change	Distribution of Members	Distribution of Groups	Average Premium PMPM Pre-ACA	Average Premium Change
less than -20.0%	13.5%	16.0%	$464.95	-22.9%
-20.0% to -10.1%	13.6%	13.5%	$394.01	-14.9%
-10.0% to -0.1%	16.9%	15.0%	$344.18	-4.8%
0.0% to 9.9%	14.3%	12.2%	$322.22	3.8%
10.0% to 19.9%	22.1%	20.8%	$285.63	14.3%
greater than or equal to 20.0%	19.6%	22.6%	$251.78	25.5%
Grand Total	**100.0%**	**100.0%**	**$333.09**	**0.0%**

- As Health Underwriting is eliminated, there will be some "winners & losers" within the market
- 20% of market will receive greater than a 20% increase
- 44% of market will receive some premium decreases

MCHA & Individual Market

- Due to changes in market rules under the ACA (guarantee issue, no rating for health status), high risk pool members will be part of the individual market in CY 2014
- Assumed that MCHA members will migrate over to Individual Market
  - 40% Migrate to Individual Market in CY 2014 (11,000 members)
  - 60% Migrate to Individual Market by CY 2015 (16,500 members)
  - 80% Migrate to Individual Market by CY 2016 (22,000 members)
- Reviewed MCHA Distribution of Claims and assumed healthier members would migrate to Individual Market
  - Members who migrate to Individual Market from MCHA have, on average, claims costs that are 70% lower than members who remain in MCHA

MCHA & Individual Market CY 2016 Premium Impact



MCHA Funding

- MCHA Assessment: $143M in CY10; Estimated as a 2.4% increase in commercial rates
- MCHA funding may still be required in CY 2014
  1. Continue to use MCHA Assessment for funding, but assessment could be reduced each year as membership declines
  2. May be able to use funds from Temporary Individual Market Reinsurance Fund
     - Note this is for the entire Individual Market. Unsure how much would be allocated to MCHA, as the Individual Market may jump to 500K in CY 2016
     - Also, HHS Regulations specify that reinsurance program will most likely be a "corridor" type program. (threshold, coinsurance, reinsurance cap)
       - Healthy NY – 90% of claims will be reimbursed between $5,000 and $75,000
       - MCHA will still need to fund claims up to the threshold, the coinsurance difference, and claims above the reinsurance cap.

Premium Changes Individual Market CY 2016

	Scenario 1	
	Children <150%FPL, NO BHP	
	Minimum	**Maximum**
Minimum Essential Benefit Requirement	**8%**	**11%**
MCHA	**10%**	**15%**
New Risk Mix of Individual Market Pool	**15%**	**20%**
Managed Competition Effect	**-7.5%**	
Premium Change	**26%**	**42%**
Best Estimate	**29%**	

- Premium changes do not include the 2010 changes estimated at 1% to 3% (preventive services, annual limits, and lifetime limits)
- Overall impact due to elimination of health status rating is 0% (however each individual may be impacted differently)

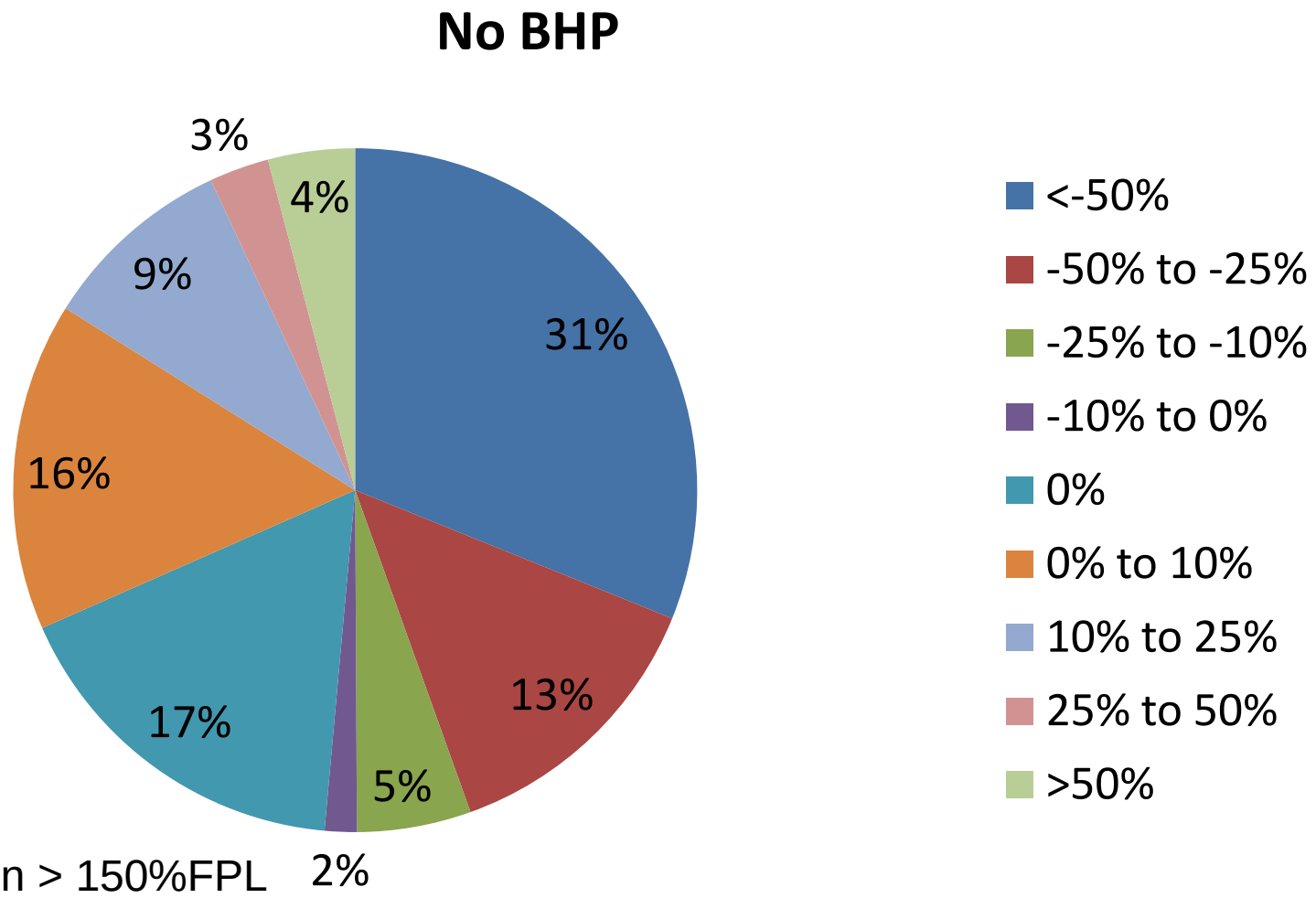
All adjustments are multiplicative not additive

Premiums and Actuarial Values for those Remaining on Nongroup: 2016

No BHP	No Reform	With Reform (No Subsidies)	With Reform (With Subsidies)
Average Nongroup Premium	$4,360	$5,630	$3,350 (-23%)
Average Nongroup Actuarial Value	0.643	0.704	0.704
With BHP	No Reform	With Reform (No Subsidies)	With Reform (With Subsidies)
Average Nongroup Premium	$4,380	$4,970	$3,420 (-22%)
Average Nongroup Actuarial Value	0.642	0.682	0.682

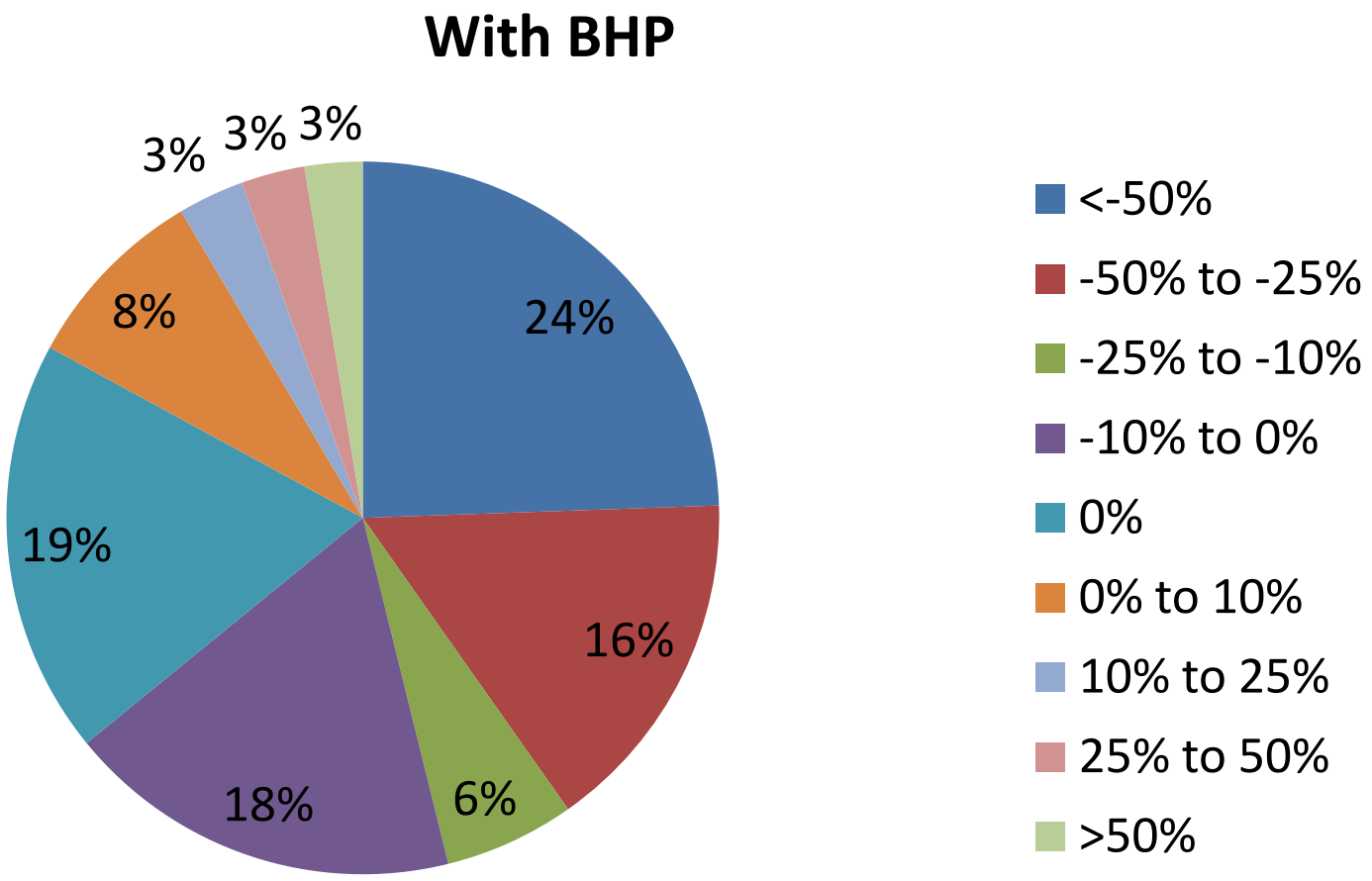
Includes children > 150%FPL

Nongroup Premium Changes (including tax credits) for those remaining on nongroup: 2016



Includes children > 150%FPL

Nongroup Premium Changes (including tax credits) for those remaining on nongroup: 2016



Includes children > 150%FPL

Part IV: State Spending Impact

Major Effects on State Spending in 2016

- State costs from newly eligible enrollees
  - 100% of costs is paid by federal government by 2017
- State costs of increased enrollment from previously existing eligibles
  - 50% of total cost is matched by federal government
- State savings from existing child/parent enrollees who leave public insurance
  - 50% of state savings is shared with federal government
- State savings from existing childless adults who leave public insurance
  - State gets entire savings

State Spending Effects, 2016
(in millions of dollars)

	150 no BHP	275 no BHP
Extra spending on existing eligibles who newly take up public ex-post	$140	$280
Savings from ending of MN care (excluding childless adults)	-$290	-$130
Savings from ending of MN care (childless adults)	-$120	-$120
Net State Spending Effect	-$270	$30

BHP Impacts on Budget

- Cost: MNCare cost of those 133-200% of poverty
  - Except kids below 150% or 200% of poverty, depending on MoE scenario
- Revenues: 95% of federal tax credit spending
  - Premium cost in the exchange for that group, minus their own enrollee contributions
- Key issue: risk adjustment
  - No risk adjustment: feds use 95% of the premiums in the exchange after BHP in place
  - Risk adjustment: feds use 95% of what the premiums would have been for the 133-200% group if they were in the exchange

BHP Financing

	Case I: 150%		Case II: 275%	
BHP Statistics	Non Adjusted	Risk Adjusted	Non Adjusted	Risk Adjusted
BHP enrollment	155,000	155,000	104,000	104,000
Average public cost for BHP enrollees:	$6,260	$6,270	$6,950	$6,960
Average exchange premium for BHP enrollees (before subsidies):	$5,030	$5,650	$5,520	$6,500
Enrollee contribution	$660	$660	$750	$750
Average exchange subsidies for BHP enrollees:	$4,370	$4,990	$4,770	$5,740
Total BHP funding (millions)	**$640**	**$740**	**$470**	**$570**
Total BHP costs (millions)	**$950**	**$950**	**$700**	**$700**
Deficit of BHP	**($310)**	**($210)**	**($230)**	**($130)**

Note: Calculations assume Medicaid provider rates (with 5% FFS reduction and 15% managed care reduction) and Medicaid/MinnesotaCare benefits

Note: Funding includes 95% of both premium subsidies and cost sharing subsidies

BHP: Alternative Scenarios

- Alternative #1: Different capitation rate changes (relative to baseline 15% MC / 5% FFS reductions)
  - No change in cap rates
  - 10% / 5% reductions
  - 20% / 5% reductions
- Alternative #2: Pay private rates for BHP
- Alternative #3: BHP enrollees pay exchange contributions (as % of income)
- Alternative #4: BHP enrollees get exchange AV
- Results only for Case I (150%) for now

Alternative BHP Scenarios (millions of dollars)

	BHP Funding	BHP Costs	BHP Deficit/Surplus
Baseline Results	$740	$950	-$210
Zero Capitation Change	$740	$1,060	-$320
10/5% Capitation Change	$740	$980	-$240
20/5% Capitation Change	$740	$920	-$180
Private Rates	$740	$1,100	-$360
Apply Exchange Enrollee Premiums	$740	$850	-$110
Apply Exchange AVs	$740	$840	-$100

*Case I 150%FPL
Risk Adjusted

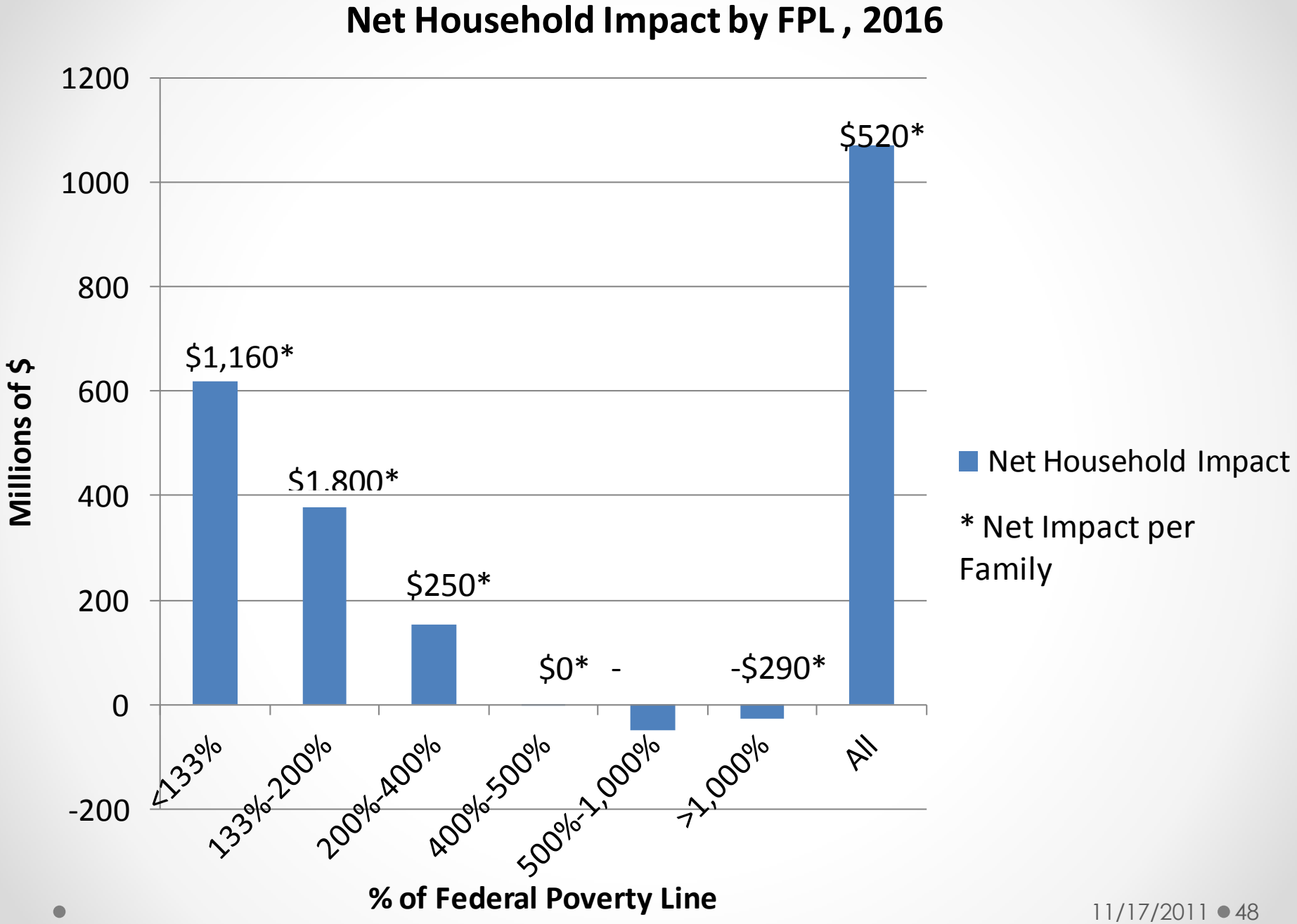
Part V: Household Budget Impact for Case 1 (150%)

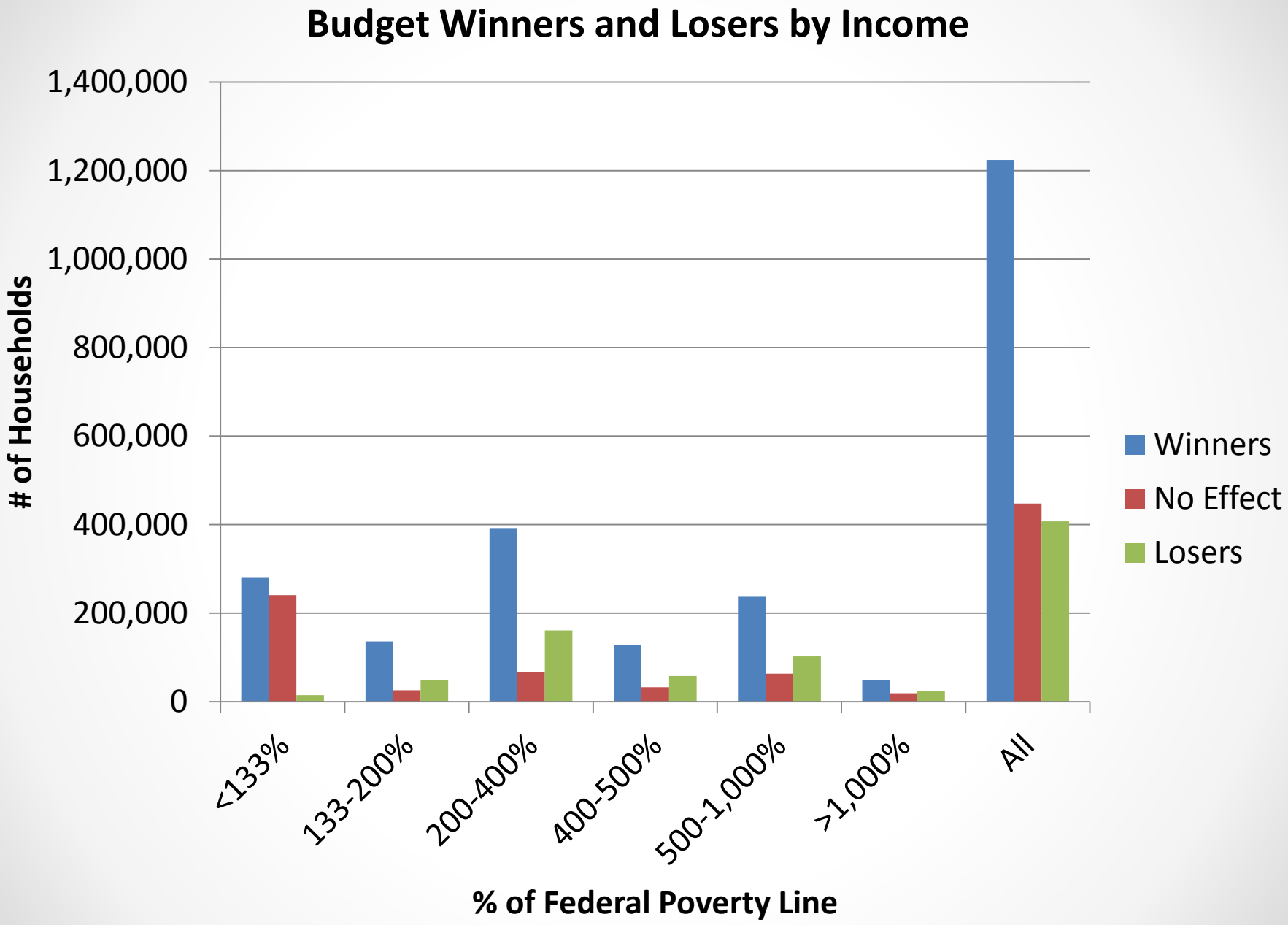
Major Effects on Household Budgets in 2016

- Change in wages due to change in employer insurance spending
- Exchange credits for those who were previously uninsured
- Public insurance spending on previously uninsured
- Change in employee contributions towards ESI
- Change in individual market premiums (including tax credits)
- Change in out of pocket spending
- Change in taxes (including increased Medicare tax)
- Excluded: other forms of financing (e.g. reductions in payments to hospitals)

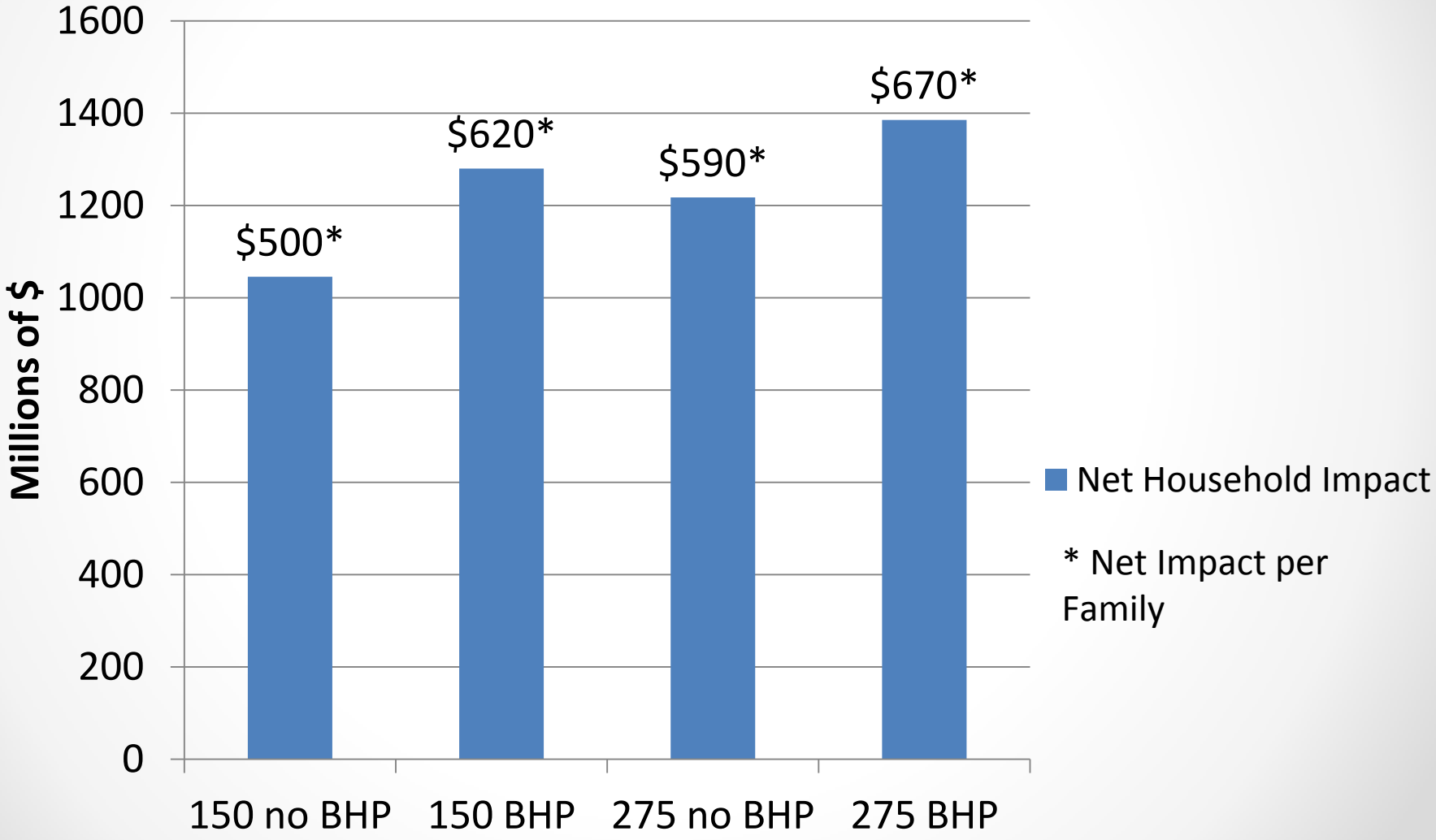
Household Budget Effects: 2016

	Status Quo (in billions)	After ACA (in billions)	ACA Effect (in billions)	Per Household Effect
Wages	$156.3	$156.2	-$0.1	-$10
Exchange Credits	$0.0	$0.4	$0.4	$210
Public Insurance	$0.0	$0.4	$0.4	$200
ESI Contribution	$4.0	$3.7	$0.3	$120
Non-group Premium	$1.1	$1.1	$0.0	$10
OOP Spending	$2.5	$2.5	$0.0	$10
Taxes	-$32.0	-$32.0	-$0.0	-$30
Net Effects			$1.0	$510


Net Household Impact by FPL , 2016
1200
1000
800
600
400
200
0
-200
Millions of $
$1,160*
$1,800*
$250*
$0*
-
-$290*
$520*
<133%
133%-200%
200%-400%
400%-500%
500%-1,000%
>1,000%
All
% of Federal Poverty Line
Net Household Impact
* Net Impact per Family


Budget Winners and Losers by Income
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
# of Households
<133%
133-200%
200-400%
400-500%
500-1,000%
>1,000%
All
% of Federal Poverty Line
Winners
No Effect
Losers

Aggregate Household Impacts, 2016

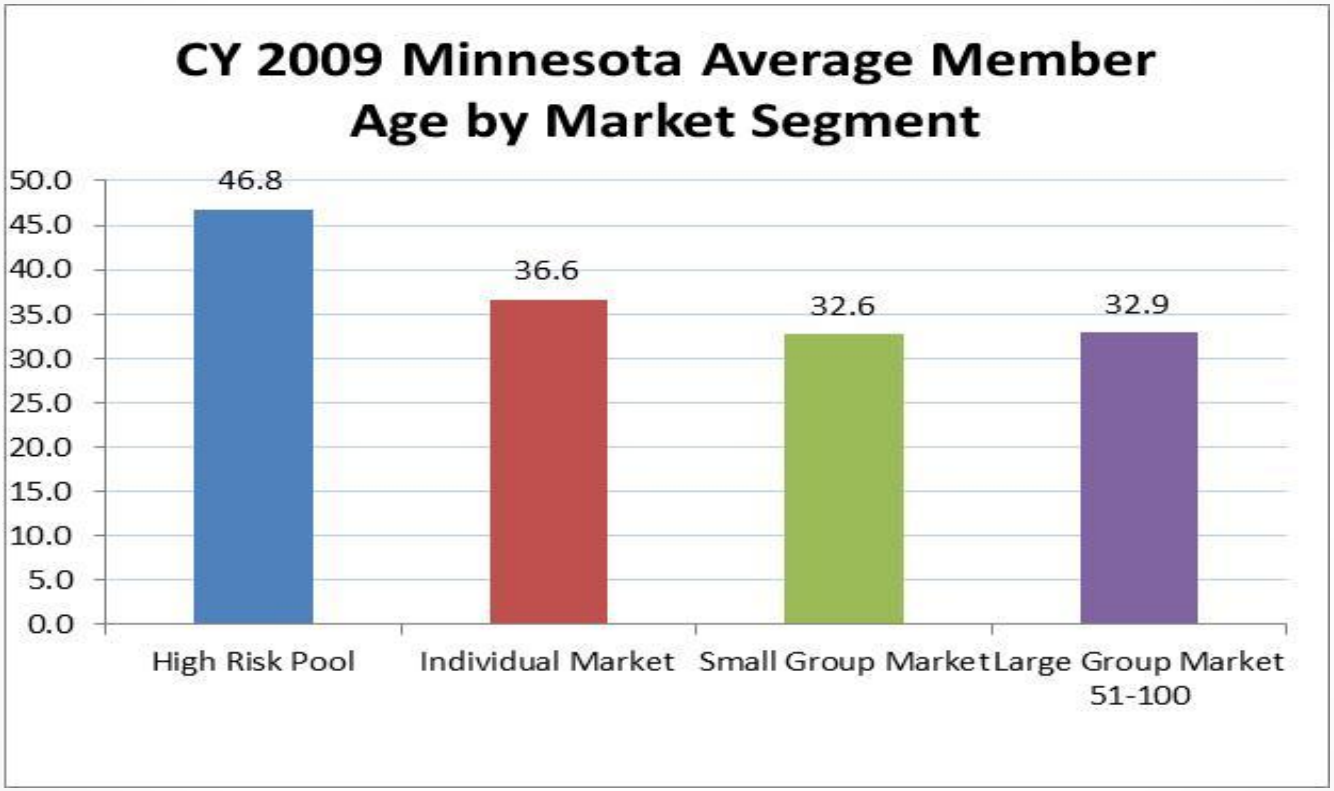


Part VI: Merged Market Analyses

Merged Market Methodology

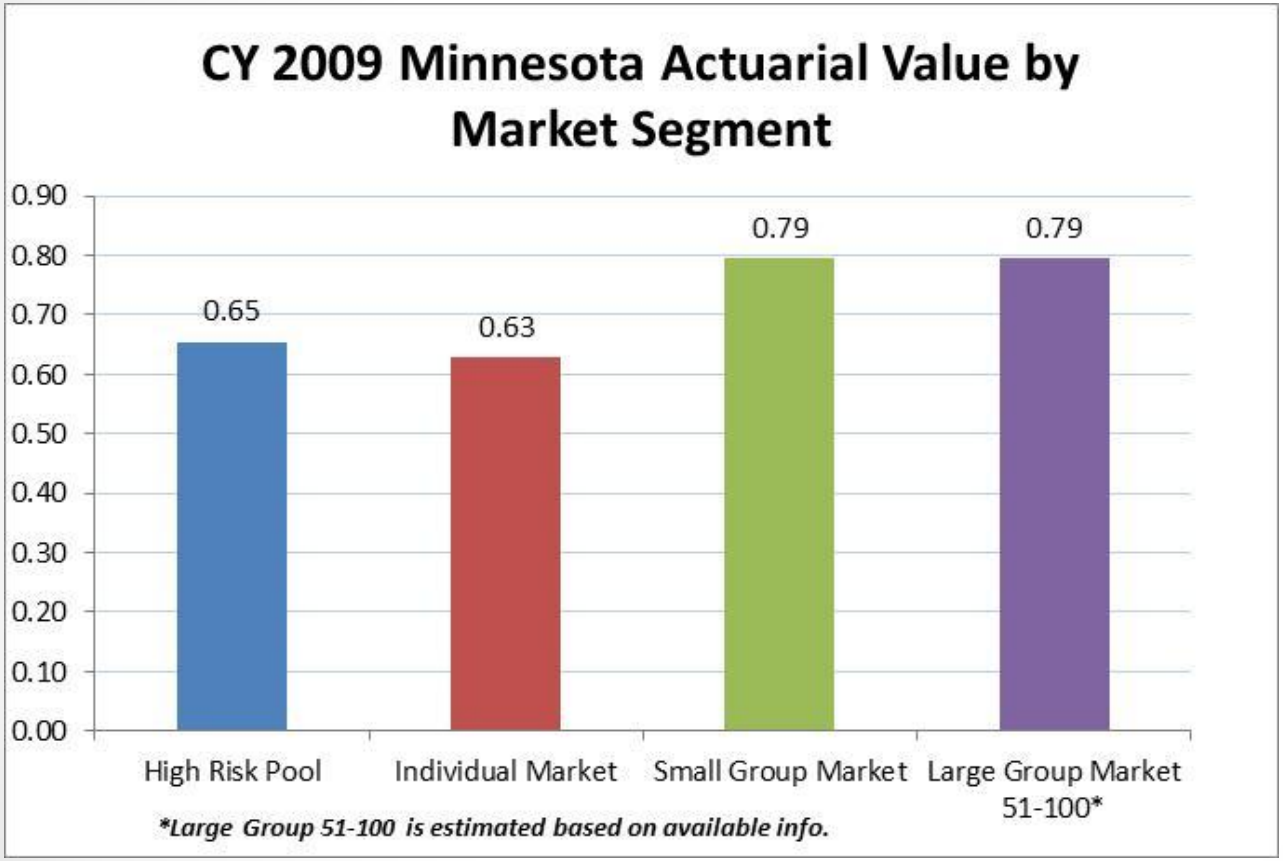
- Analyzed claims data, benefit designs and demographic information by market segment
- Adjust incurred claims PMPM for benefit design differences (actuarial value) and demographics
  - Actuarial value calculated using internal pricing model
- Geographic information not available, therefore no adjustment possible
- Adjusted Individual Market Claims PMPM for new risk that will be entering the market (using output from GMSIM)
- Compared these adjusted incurred PMPM's and total membership to determine impact by market segment

Market Segment Demographics



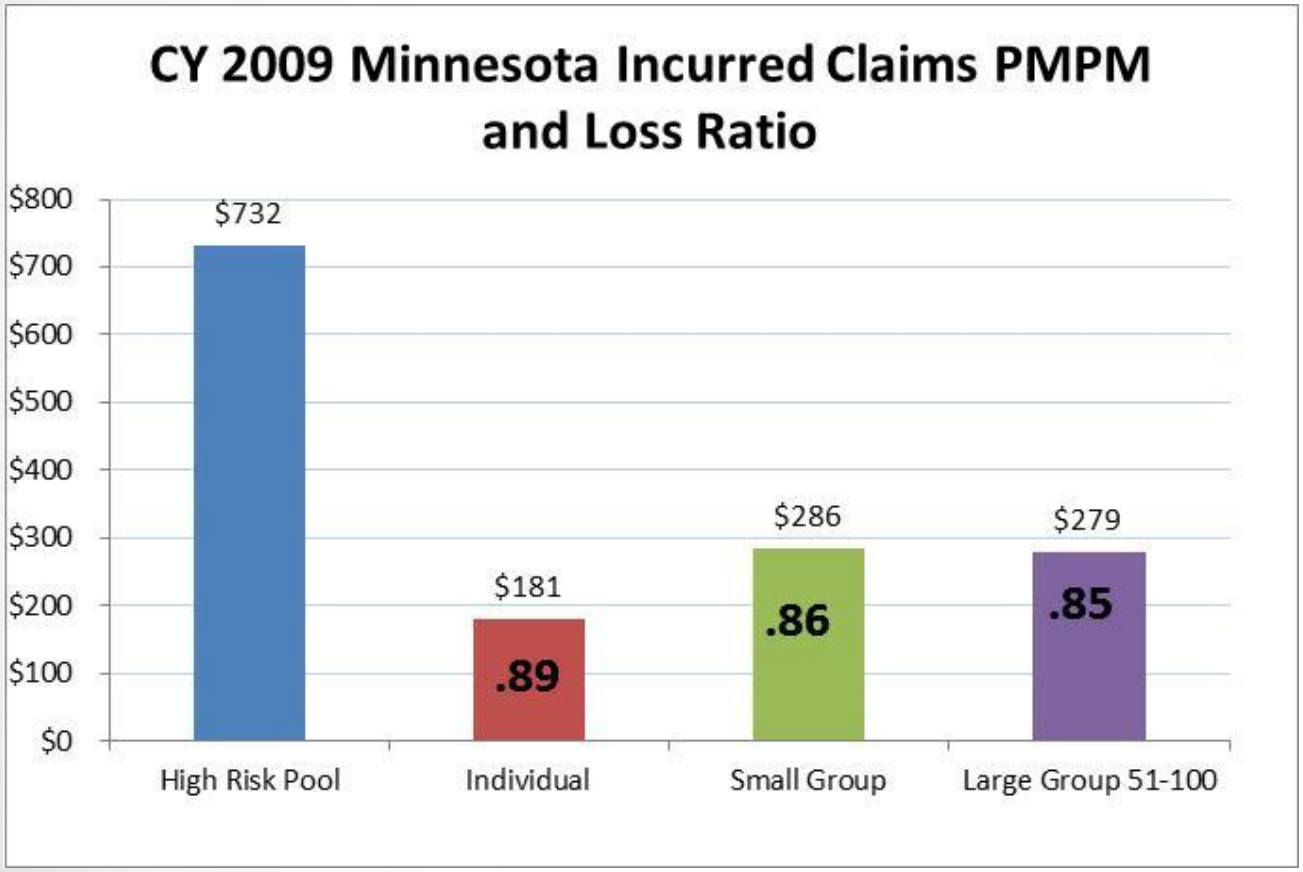
- The HRP has the highest average age at 47 years old, while the Small Group and Large Group 51-100 Markets have the youngest average population at 33 years old.

Market Segment Actuarial Value



- Actuarial Value is a measure of the average proportion of medical expenses paid by a health plan for a given plan design
- HHS has not yet provided guidance on calculating actuarial value
- Gorman Actuarial developed high level actuarial value estimates for MN plan designs

Market Segment Financial Comparison



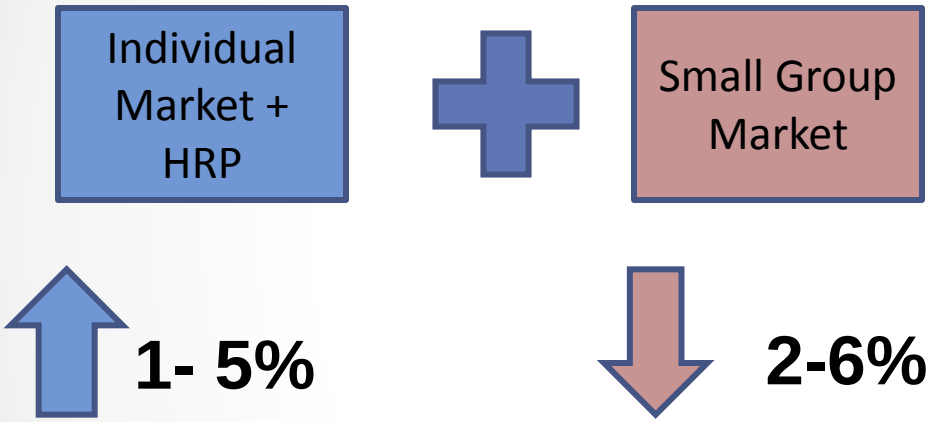
- The incurred claims PMPM in the Small Group and Large Group 51-100 Markets are higher than the Individual Market, driven in part by the richer plan designs in these markets.
- The incurred claims PMPM for the HRP is significantly higher than all the other markets. The older demographics of the HRP is a significant driver of the large claims difference.

Individual Market Changes Scenario 1

Scenario 1: No BHP; Children up 150% FPL in Public Program

- Estimated that as a result of ACA and the Individual Mandate and premium tax subsidies, the Individual Market membership will increase **~100+%**
  - **~**Average CY 2016 Individual Market membership 500K
- New entrants into the market will increase risk pool costs ~17% (over and beyond HRP addition)
- There is no significant change to Small Group (~400K) or Large Group 51-100 (~100K) Markets, but given the large growth in the Individual Market, this market now represents more than half of this pool in CY 2016.

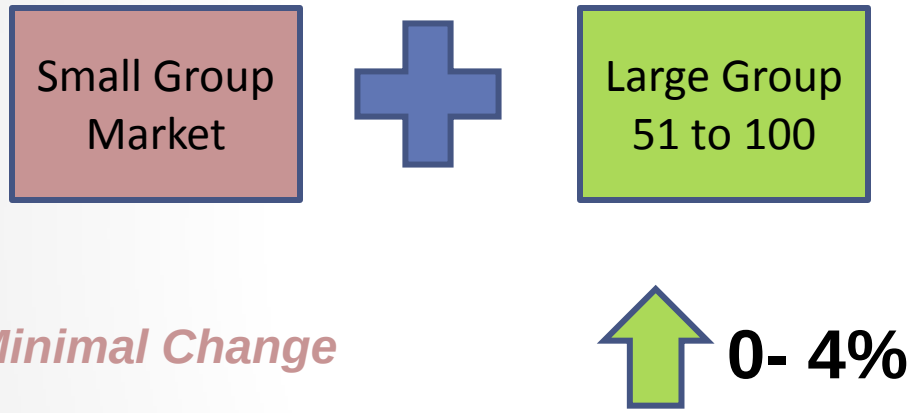
Merged Market Policy Decisions



Scenario 1 – CY 2016

- Results will change based on when merging occurs
- After CY 2014, markets will look different due to premium tax subsidies, Individual Market will be larger
- Federal Health Reform allows states to merge these markets, it is not mandatory
- Individual Market impact is incremental to impact from HRP & Individual Merge and changes to Individual Market from ACA

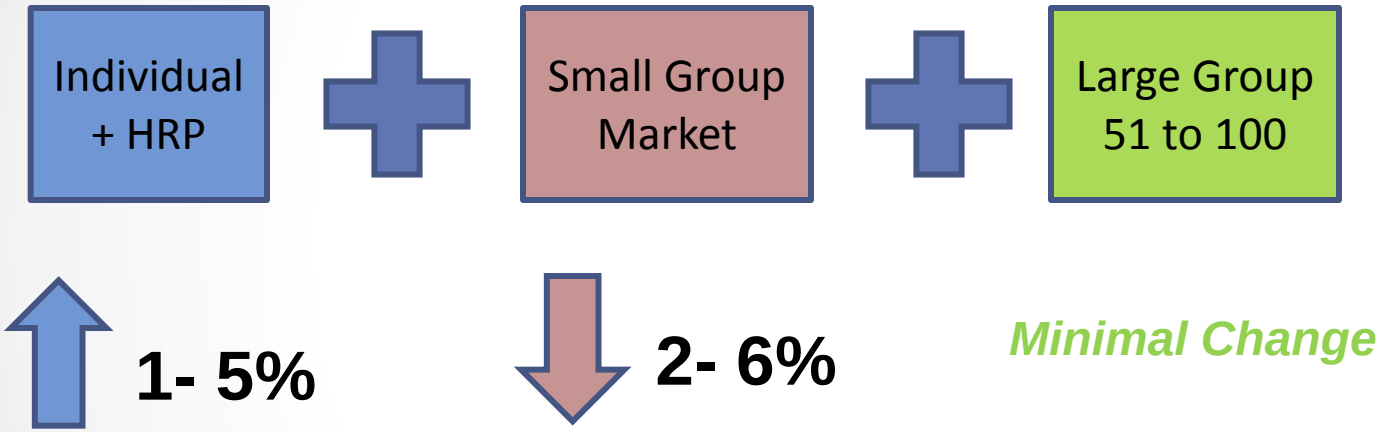
Merged Market Policy Decisions



Scenario 1 – CY 2016

- Federal Health Reform requires this merging to take place in CY 2016
- States have the option to limit to 50 prior to CY 2016
- Given that the relative claims difference in these two markets are fairly close, there is little impact to either market when the are merged
- However, due to community rating, there may be a shift to ASO for the 51 to 100 market
  - This will have an adverse impact on rating pool as healthy groups shift to ASO block

Merged Market Policy Decisions



- Option to merge all three markets prior to CY 2016
- The Individual Market has lower morbidity while the Small Group Market has higher morbidity

Scenario 1 – CY 2016

Individual Market Summary of Scenarios

Scenario Number	Children in Public Program	BHP	2016 Individual Market	Individual Market Growth	Risk Adjustment
Scenario 1	Children < 150%FPL	No	520,372	260,613	17%
Scenario 2	Children < 150%FPL	Yes	365,069	105,310	1%
Scenario 3	Children < 275%FPL	No	397,774	138,015	33%
Scenario 4	Children < 275%FPL	Yes	293,829	34,070	9%

Output from GMSIM

* Risk Adjustment does not include HRP impact

Merged Market- Scenarios

Individual + HRP Impact Small Group Impact Large Group 51-100 Impact	Merge IND + HRP and Small Group	Merge Small Group and Large Group 51-100	Merge IND + HRP and Small Group and Large Group 51-100
Scenario 1: no BHP and Children under 150% FPL in Public Program	↑ 1-5% ↓ 2- 6%	Minimal Change ↑ 0- 4%	↑ 1- 5% Minimal Change ↓ 2- 6%
Scenario 2: with BHP and Children under 150% FPL in Public Program	↑ 11- 15% ↓ 8-12%	Minimal Change ↑ 0- 4%	↑ 12- 16% ↓ 5- 9% ↓ 7- 11%
Scenario 3: no BHP and Children under 275% FPL in Public Program	↓ 1- 5% ↑ 1- 5%	Minimal Change ↑ 0- 4%	↓ 1- 5% ↑ 3-7% ↑ 0- 4%
Scenario 4: with BHP and Children under 275% FPL in Public Program	↑ 7- 11% ↓ 4- 8%	Minimal Change ↑ 0- 4%	↑ 7- 11% ↓ 1- 5% ↓ 4- 8%

Pros & Cons of Merging Individual and Small Group

Pros

- Creating a larger risk pool will help spread risk of catastrophic claims over larger population, decreases volatility
- Scenario 3: Individuals may experience decreases encouraging enrollment
- Other Scenarios: Small Groups may experience slight decreases
- If defined contribution approach in SHOP Exchange grows, the rating approach in both markets may be the same.

Cons

- Scenario 3: Small Groups may experience slight increases to their premiums which may discourage participation
- There may be significant costs and administrative challenges to merging markets.
- It may make sense to hold off on making a decision to merge markets until the post-ACA health care environment can be analyzed further.

Pros & Cons of Merging Small Group and Large Group 51 to 100 Prior to CY 2016

Pros

- Creating a larger risk pool will help spread risk of catastrophic claims over larger population, decreases volatility
- Will happen in CY 2016, implementing sooner can provide time to work out complications
- Many changes will take place in CY 2014 anyway, why not redefine small group at the same time?

Cons

- There will be no significant impact on either market's premium by merging the two markets, therefore there is no clear advantage to merging prior to CY 2016.
- 51 to 100 generally partially experience rated. If forced to move to adjusted community rating, healthier groups may seek ASO coverage which could deteriorate the risk pool.
- The definition of Small Group has to be expanded by CY 2016, so it may make sense to wait rather than opting to introduce more change earlier than necessary.

Part VII: “Other” Taxes and Assessments

Temporary Reinsurance Program ACA

- Program is Temporary 2014 through 2016 and for the Individual Market
- Funding will be based on market assessments based on percent of premium or premium equivalent (ASO Market)
- HHS to determine assessment charge: Note funding amount decreases each year.
  - CY 2014 $10B
  - CY 2015 $6B
  - CY 2016 $4B
- Note, as funding decreases each year and Individual Market enrollment increases each year, the effect of the reinsurance program gets smaller
- HHS had indicated a 15% premium reduction in CY 2014: However this is when Individual Market is the smallest and funding is the greatest.
- Estimated the premium reduction for the MN Individual market in CY 2016 ~2.5%
- However the rest of the market's premiums will increase up to ~ 0.5% due to the reinsurance program assessment

Other Impacts to Individual Market

- **<u>Imposition of Annual Fee on Health Insurers</u>**: ($8B CY14, $11.3B CY15-16, $13.9B CY17, $14.3B CY18)
  - Based on market share by premium (all Commercial, Medicare and Medicaid health plans; 50% effect for non-profits; non-profits with > 80% of gross revenues from government programs and those plans with < $50M in premiums are exempt)
  - This is a fee collected by the Federal government to offset expected carrier gains
    - Assume that carriers will build this into their premiums
  - Estimated the CY 2016 fee based on CY2016 enrollment and the percentage of premiums reported in 2010 SHCE for MN
    - MN Insurance Carrier Annual Fees in CY 2016 → $175M
    - Estimated Increase to Premiums is approximately **1%**